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CHILD/ADOLESCENT FULL ASSESSMENT

Date of first assessment contact:			
Assessing Practitioner (Name and D	iscipline):		
	Identifying Inform	nation & Special Service Nec	eds
	Child	1	Agency of Primary Responsibility
Name:	DOB:	Refer to "MH 525: Contact Information"	
Other Names Used:		form for detailed contact information. DMH DCFS	
Ethnicity: Preferred Language:			DMH DCFS Probation School District
Referred by (Name & Number):			Others
		rents & Contact Information	
Mother's Name:		Father's Name:	
Marital Status:			DOB:
Address:			
Phone: Wo			Work:
Preferred Language:			
Interviewed: Yes No Int	• — —		o Interpreter Used: Yes No
Language Used for Interview:		L	ew:
Primary Caregiver ☐ Adoptive ☐ Gu		(Complete only if Biological Paren Kinship/Relative	it is not the Primary Caregiver) Group Home Other
Name:	R	elationship to Child:	DOB:
Address:			
Marital Status:			
Preferred Language: Language Used for Interview: Interpreter Used: \(\sum \) Yes \(\sum \) No			
Physically challenged (wheelch	air, hearing, visual, etc.) sp	pecify:	
	Reason for 1	Referral/Chief Complaint	
Describe precipitating event(s)/Rea			
	(intensity, duration, onset, f	frequency) and Impairments in Life I	⁷ unctioning caused by the
This confidential information is provided to Federal laws and regulations including but not		Name:	IS#:
Institutions Code, Civil Code and HIPAA Pr this information for further disclosure is p	ivacy Standards. Duplication of		
authorization of the client/authorized represe otherwise permitted by law. Destruction of thi	ntative to who it pertains unless	Agency:	Provider #:
-4-4-3		Los Angeles County —	Department of Mental Health

Mental Health History Psychiatric Hospitalizations: Yes No Unable to Assess If yes, describe dates, locations, and reasons Outpatient Treatment: Yes No Unable to Assess If yes, describe dates, locations and reasons.
Psychiatric Hospitalizations: Yes No Unable to Assess If yes, describe dates, locations, and reasons Outpatient Treatment: Yes No Unable to Assess
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Outpatient Treatment: Yes No Unable to Assess
If yes, describe dates, locations and reasons.
Recommendations, Response to Treatment, Parent/Child Satisfaction
Past Suicidal/Homicidal Thoughts/Attempts including dates, threat, intent, plan, target(s), access to lethal means, method used:
Prior Mental Health Records Requested: Yes No
Prior Mental Health Records Requested from:
History of Thoums on Eurogene to Thoums. Ves No Librable to Assess
History of Trauma or Exposure to Trauma: Yes No Unable to Assess Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4)
been a combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6)
witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime?
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Medications	Mediantions				
List "all" past and present psychotropic medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.					
Medication	Dosage/Frequency	Period Ta	akon	Effectiveness/Response/Side Effects/Reactions	
Medication	Dosage/Frequency	I CI IOU I	IKCII	Effectiveness/Response/Side Effects/Reactions	
General Medication Cor	mments (include significat	nt non-psyc	notic medication	n issues/history):	
	se & Attitudes/Expo				
☐ Child under the age	of 11 AND substance use	screening r	ot required base	ed on clinical judgment	
"MU554 Co Occumin	g Substance Use Child Sc	maanina In	C+411144 014+ ³³		
	stions checked "Yes"?			olete MH 553*	
"MH552 –Parent/Cares		105	.vo ii yes, comp	office WIII 333	
		cal iudgmen	t? ☐ Yes ☐	No If yes, complete MH 553*	
				rugs? Yes No Unable to Assess	
	st time the client used alco				
		or his/her u	se of alcohol or	drugs? Yes No Unable to Assess	
Comments on alcohol/o	drug use:				
TT	4 11 1 4		•	0.36 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Substance Use/Abuse.	mpacted by substance us	se (clinician	's perspective)	? Must be completed if any services will be directed towards	
Substance Use/Abuse.					
* MH 553 "Supplementa	al Co-Occurring Disorder	s Assessme	nt" completed or	n:	
Medical History					
Pediatrician Name:				Pediatrician Phone:	
Date of Last Physical Ex	xam:				
Glasses		Braces		☐ Yes ☐ No Sensory/Motor Impairment ☐ Yes ☐ No	
Seizure/Neuro Disorder	Yes No	Acute Illnes	S	☐ Yes ☐ No Chronic Illness ☐ Yes ☐ No	
Accidents		Head Traun		Yes No Hearing Problems Yes No	
Dental		Vaccination		Yes No Asthma/Lung Disease Yes No	
Sexually Transmitted Di		Weight or A	Appetite Change	Yes No	
Allergies Yes No				HIV Test Yes No If yes, date:	
Pregnant Yes No	o If yes, date:				
Medical Comments:					
Records requested from:					
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	and HIPAA Privacy Standards. I disclosure is prohibited without		A	D *1 #.	
authorization of the client/auth	orized representative to who it p	ertains unless	Agency:	Provider #:	
other wise permitted by law. Des	t. e.ien. i	un eu aitef tile	Lo	s Angeles County _ Department of Mental Health	

Developmental Hist	ory		
Neonatal: Prenatal Care?		Term: Mos.	Birth Wt
Place of Delivery:		Age of Mother: A	ge of Father: Marital Status:
Did Mother use alcohol,	cigarettes, drugs? Specify:		
	s during pregnancy or at the time of p	•	
Post-Partum complication	ns:		
Comments (include famil	y and environmental stressors during	pregnancy and at birth):	
	Developmental Milestones		Environmental Stressors
	(Describe if not within normal limits	s)	Moves; schools; losses of fam/friends, changes in fam composition; SES, lifestyle; exposure to fam conflict/violence; major illnesses; abuse; placements, etc.
Infancy (0-3)			Infancy (0-3)
Motor – sit, crawl,			
walk Speech; Eat; Sleep			
Toilet training			
Coordination			
Temperament			
Separation			
Early Years (4-6) Social Adjustment Separation Sexual Behaviors Self-Care			Early Years (4-6)
Latency (7-11)			Latency (7-11)
School adjustment			
Peer & adult			
relations/friends Interest/hobbies			
Impulse control			
Self-Care			
Adolescence (12-on)			Adolescence (12-on)
Separation/individ.			
Sexual orientation			
Sexual behavior Gender identity			
Relationships/Support			
Systems			
Independent funct.			
Moral development			

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Name:

IS#:

Agency:

Provider #:

Psychosocial History				
School History, Current Status & Aspirations				
School:	Grad	le Level:		
Special Education: Yes No		cial Classes: Yes No		
IEP: Yes No Dates:	•			
IEI. Tes Two Dates.				
Educational Comments: Type of School, Academic Perl Attendance/Truancy, Suspension	formance, C	Grade Retention, School Changes, Attitude/Behavior,		
Vocational Information (jobs, independent living programme)	ram, trainin	g, job related problems, volunteer work, career interests)		
Juvenile Court History (arrests/offenses, tickets/warning)	igs, probatio	on/stipulations, incarceration, placement)		
Child Abuse and Protective Services Information (nature of allegations, age of occurrence, offender, dependency court action, child/parent response, placement and type, services)				
DCFS or Police Intervention: Yes No Is there a current visitation/involvement plan? Yes No				
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Current Living Situation			
Living Situation Type: Biological Adoptive Others Diagnosed with Mental Illness in Living Situation: Significant Current Drug/Alcohol Use in Living Situation:	Yes No		
Family Composition (Include siblings, stepparents/others, greligious affiliation)	grandparents, extended family, ethnicity/culture, education, socio-economic,		
Family History: History of Mental Illness in Immediate Family: Yes Alcohol/Drug Use in Immediate Family: Yes History of Incarceration in Immediate Family: Yes Family History (including medical, mental, substance use, leg	☐ No ☐ Unable to Assess ☐ No ☐ Unable to Assess ☐ No ☐ Unable to Assess egal)		
Family Relationships (quality of attachment, disciplinary styl	rle, conflict/violence, problem solving)		
Family Strengths (client/family perspective, assessor's perspe	pective)		
Family Needs (client/family perspective, assessor's perspective	zive)		
Stated Needs and Expectations What are the family members/child expecting of mental health and interagency system? What are they willing to contribute?			
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Relevant Past Living Situation				
Living Situation Type: Biological Adoptive Others Diagnosed with Mental Illness in Living Situation: Significant Current Drug/Alcohol Use in Living Situation:				
Family Composition (Include siblings, stepparents/others, grandparents, extended family, ethnicity/culture, education, socio-economic, religious affiliation)				
Family History: History of Mental Illness in Immediate Family:				
Family Relationships (quality of attachment, disciplinary style, conflict/violence, problem solving)				
Family Strengths (client/family perspective, assessor's perspe	ective)			
Family Needs (client/family perspective, assessor's perspective)				
Family/Child's Current Visitation & Involvement Plan and Schedule (Complete only if client does not reside with family of origin)				
What is the family's current court-ordered visitation plan? Biological Parents Stepparents/Siblings Extended Family Frequency of visits, length, need for monitoring Engagement in child's assessment	in does not reside with raining of origin)			
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Revised 02/04/14 **Mental Status** Provide a word picture of this child based on your observations. Be sure to address relevant features from each **bolded** category in the left column. **Appearance** Dress, grooming, unusual physical characteristics **Behavior** Activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity **Expressive Speech** Fluency, pressure, impediment, volume **Thought Content** Fears, worries, preoccupations, obsessions, delusions, hallucinations **Thought Process** Attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g. planning) Cognition Orientation, vocabulary, abstraction, intelligence Mood/Affect Depression, agitation, anxiety, hostility absent or unvarying, irritability Suicidality/Homicidality Thoughts, behavior, stated intent, risks to self or others. access to lethal means Attitude/Insight/Strengths Adaptive capacity, strengths & assets, cooperation, insight,

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judgment, motivation for

treatment.

Name:

IS#:

Agency:

Provider #:

Summary and Diagnosis				
I. Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)				
justification for diagnosis)				
TI A I I I DI COMPANIA DI COMP	~ .			
II. Admission Diagnosis (check one Principle and one Axis I ☐ Prin ☐ Sec Code		4		
-		d with a deferred diagnosis)		
Sec Code	-	iture		
Code		ture		
Code		ture		
Code		ture		
Axis II Prin Sec Code	Nomencla	ture		
Sec Code		ture		
Code		ture		
Axis III				
				
				
Axis IV Psychological and Environmental Problems w	which may affec	diagnosis, treatment, or prognosis		
Primary Problem #:				
Check as many that apply: 1. Primary support group 2. Soc	ial environment	3. Educational 4.	Occupational	
5. Housing 6. Eco		7. Access to health care 8.	Involve w/Legal Sys	
9. Other psychosocial/environmental		10. Inadequate information		
Axis V Current GAF:	Axis V Current GAF: DMH Dual Diagnosis Code:			
III. Specialty Mental Health Services Medical N 1. Medi-Cal Specialty Mental Health Included Diagnos		eria: □ Yes □ N	0	
2. Significant impairment in life functioning due to the				
3. Expectation that proposed interventions can impact the client's condition Yes No				
4. Mental Health Condition will not be responsive to physical health care based treatment Yes No				
IV. Disposition/Recommendations/Plan				
V. Signatures				
v. Digitatures				
Assessor's Signature & Discipline	Date	Co-Signature & Discipline	Date	
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